State of California—Health and Human Services Agency
Department of Health Services

California
Department of
Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

February 18, 2003

Dear Interested Parties:

CENTRAL VALLEY COUNTIES TWO-PLAN MODEL COMMERCIAL PLAN REQUEST FOR PROPOSAL (RFP) 02-25804 ADMINISTRATIVE BULLETIN 5, ADDENDUM 1.

Enclosed you will find Administrative Bulletin 5, Addendum Number 1 to the Request for Proposal (RFP) for the Central Valley Counties Two-Plan model Commercial Plan. This addendum incorporates changes to the RFP that correct inaccuracies discovered in the review of the RFP. Within the text of the document, changes are highlighted to denote revisions.

Any changes made to the RFP are published as additional or replacement pages to the RFP. Because the RFP is available in hard copy and in an electronic version, two tables are included in this bulletin. The instructions for updating the hard copy version are for the replacement pages enclosed, which are double-sided.

In order to configure the RFP so that it accurately reflects the current requirements and considerations, add the new page or remove the existing page and insert the appropriate replacement page as indicated in the following table:

HARDCOPY VERSION

REMOVE EXISTING PAGES	ADD NEW/REPLACEMENT PAGES
RFP page 18 & 19. Subsection o. Enrollments and Disenrollments, third paragraph. Typographical error.	RFP page 18 & 19. Subsection o. Enrollments and Disenrollments, third paragraph. Typographical error. The text **"**come back."** (DELETED)
RFP Page 26 & 27 Section J, Qualification Requirements, item 1. Knox-Keene Licensure: correction and clarification..	RFP Page 26 & 27 Section J, Qualification Requirements, item 1. Knox-Keene Licensure: correction and clarification.
RFP Page 34: No changes.	RFP Page 34: No changes.
RFP Page 35. Item 3. Management Information System, technical proposal requirement c: Amended to clarify requested	RFP Page 35. Item 3. Management Information System, technical proposal requirement c: Amended to clarify requested

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REMOVE EXISTING PAGES	ADD NEW/REPLACEMENT PAGES
information.	information.
RFP Page 36 & 37. No change - text moved to next page due to changes on page 35.	RFP Page 36 & 37. No changes - text moved to next page due to changes on page 35.
RFP Page 60 through 66. Page 60 and 61, lettered items J. and K. are subparagraphs under item I. Lettering was deleted from these paragraphs and remaining items were re-lettered. No changes were made on pages 62 through 66 – changes to page 60 caused text to move on these pages.	RFP Page 60 through 66. Page 60 and 61, lettered items J. and K. are subparagraphs under item I. Lettering was deleted from these paragraphs and remaining items were re-lettered. No changes were made on pages 62 through 66 – changes to page 60 caused text to move on these pages.
Attachments: RFP Attachment 2. Page 1 & 2. First item is amended.	Attachments: RFP Attachment 2. Page 1 & 2. First item is amended.
Exhibit A, Attachment 18, Page 1: Paragraph 2: comma added in first sentence. Paragraph 4: last sentence, the word "Provision" added (provision 17) New paragraph regarding Knox-Keene Licensure added.	Exhibit A, Attachment 18, Page 1: Paragraph 2: comma added in first sentence. Paragraph 4: last sentence, the word "Provision" added (provision 17) New paragraph regarding Knox-Keene Licensure added.
Exhibit A, Attachment 18, Page 2: No changes, text moved from previous page.	Exhibit A, Attachment 18, Page 2: No changes, text moved from previous page.
Exhibit A, Attachment 18, Page 3: No changes, text moved from previous page.	Exhibit A, Attachment 18, Page 3: No changes, text moved from previous page.
Exhibit A, Attachment 18, Page 4: No changes, text moved from previous page.	Exhibit A, Attachment 18, Page 4: No changes, text moved from previous page.
Exhibit A, Attachment 18, Page 5: Item c.: Question mark removed.	Exhibit A, Attachment 18, Page 5: Item c.: Question mark removed.
Exhibit A, Attachment 18, Page 6: Item h.: Re-lettered to item i. (No changes to the text.)	Exhibit A, Attachment 18, Page 6: Item h.: Re-lettered to item i.: (no changes to the text.)
Exhibit A, Attachment 18, Page 7: No changes	Exhibit A, Attachment 18, Page 7: No changes.
Exhibit A, Attachment 18, Page 8: Item i.: Reference to Exhibit A, Attachment 6 provision 12 corrected and the text "for format" deleted.	Exhibit A, Attachment 18, Page 8: Item i.: Reference to Exhibit A, Attachment 6 provision 12 corrected and the text "for format" deleted.
Exhibit A, Attachment 18, Page 9: No changes. Text moved.	Exhibit A, Attachment 18, Page 9: No changes. Text moved.
Exhibit A, Attachment 18, Page 10,11,12,13: No changes. Text moved.	Exhibit A, Attachment 18, Page 9: No changes. Text moved.
Exhibit A, Attachment 18, Page 14:Item f.:	Exhibit A, Attachment 18, Page 14:Item f.:

REMOVE EXISTING PAGES	ADD NEW/REPLACEMENT PAGES
The text "(Evidence of Coverage and disclosure Form)" deleted.	The text "(Evidence of Coverage and Disclosure Form)" deleted.
Exhibit A, Attachment 18, Page 15: No changes.	Exhibit A, Attachment 18, Page 15: No changes.

ELECTRONIC VERSION

REMOVE EXISTING PAGES	ADD NEW/REPLACEMENT PAGES
RFP Page 18 &19.	RFP Page 18 &19.
RFP Page 26 & 27.	RFP Page 26 & 27.
RFP Page 35 & 36.	RFP Page 35 & 36
RFP Page 60, 61, 62, 63, 64, 65, 66.	RFP Page 60, 61, 62, 63, 64, 65, 66.
RFP Attachment 2.	RFP Attachment 2 (revised)
RFP Exhibit A, Attachment 18: Pages 1 through 15	RFP Exhibit A, Attachment 18: Pages 1 through 15

Thank you for your continued interest in the Medi-Cal Two-Plan Model procurement effort. If you should have any questions, please call Subran Singh, lead analyst assigned to this procurement, at (916) 323-7406.

Sincerely,

for

Donna Martinez, Chief
Office of Medi-Cal Procurement

n. Marketing

All marketing information must be true and fair and maintain the integrity of the Medi-Cal program. DHS does not tolerate marketing practices that deceive or mislead the public or disparages the competing health plan.

A variety of marketing strategies to recruit or solicit enrollment of eligible Medi-Cal beneficiaries may be used. Activities may include participation in health fairs and seminars, community outreach programs, multimedia and billboard advertisements, and development and distribution of mailers. All written marketing material must be developed with the goal to assist Medi-Cal beneficiaries in making an informed choice, and shall be clear, concise, and easily understood.

Marketing representatives must be trained and certified by the health plan before having contact with Medi-Cal beneficiaries. Primary Care Providers (PCPs) and their staff may discuss plan membership with their patients. These individuals are not required to be certified; however, the Contractor is required to communicate to network providers the requirements regarding enrollment of Medi-Cal beneficiaries. Contractor shall ensure network providers do not distribute unauthorized or unapproved marketing materials relating to its Medi-Cal Managed Care health plan to Medi-Cal beneficiaries.

All Medi-Cal marketing activities shall be in compliance with Welfare and Institutions Code, Section 14408, Health and Safety Code, Section 1361, and Title 22, CCR, Sections 53880 and 52881.

o. Enrollments and Disenrollments

Enrollment in a Medi-Cal Managed Care health plan is conducted through the DHS Health Care Options (HCO) enrollment program. The DHS' enrollment contractor administers the HCO enrollment program. To gain an understanding of the enrollment and disenrollment process, responsibilities, and requirements, refer to Title 22, CCR, Sections 53882, 53889, and 53891.

All Two-Plan Medi-Cal Managed Care Contractors are required to participate in the HCO enrollment program. The goal of the program is to provide each eligible Medi-Cal beneficiary with sufficient and consistent information about the enrollment process and the available managed care health plans. The program seeks to ensure that Medi-Cal beneficiaries are making an informed choice.

After Medi-Cal eligibility is determined, Medi-Cal beneficiaries eligible for managed care enrollment are asked to attend an HCO enrollment presentation at one of various sites within the county. The presentation includes an explanation of beneficiary rights, an introduction to accessing services through a primary care physician, an explanation of benefits, and information on the health plans available in the county. An enrollment packet is also mailed to each Medi-Cal beneficiary who has a mandatory aid code. The enrollment packet contains information similar to that provided in the presentation and will include the telephone numbers of both health plans to call for additional information.

Contractors provide the HCO program a provider directory, information to be included in a health plan comparison chart, and a local or toll-free telephone number. This information is included in the enrollment packets and distributed at the HCO presentations. DHS has issued health plan provider directory policy, guidelines and delivery standards. The policy, guidelines and delivery standards are available in the Data and Information Library as Medi-Cal Managed Care Division (MMCD) Policy Letter 00-02. See Program Appendices, Appendix 2, Data Library Catalog.

New Medi-Cal eligible beneficiaries with a mandatory aid code have thirty (30) days to select a Medi-Cal Managed Care health plan after attending an enrollment presentation or receiving an enrollment packet. If the beneficiary does not make a choice after fifteen (15) days, the HCO enrollment contractor will send a reminder letter informing the beneficiary that if no selection is made, the beneficiary will be assigned to a Medi-Cal Managed Care health plan. After the thirtieth day, the HCO enrollment contractor will send another letter to inform the beneficiary an assignment to a Medi-Cal Managed Care health plan has been made. Assignments are made in accordance with Title 22, Section 53884.

The HCO enrollment contractor processes all enrollments and disenrollments. When an eligible Medi-Cal beneficiary with a mandatory aid code disenrolls from one Medi-Cal Managed Care health plan, the beneficiary must enroll in the other Medi-Cal Managed Care health plan operating in the county; unless the beneficiary no longer meets the Medi-Cal Managed Care program enrollment criteria indicated in Title 22, CCR, Section 53845 or otherwise exempt When an eligible Medi-Cal beneficiary with a voluntary aid code disenrolls from a Medi-Cal Managed Care health plan in the county, the beneficiary may enroll in the other Medi-Cal Managed Care health plan operating in the county, or enroll in regular fee-for-service Medi-Cal, unless the beneficiary no longer meets Medi-Cal Managed Care program enrollment criteria or Medi-Cal eligibility. A combined enrollment/disenrollment form is used in this program. Contractors are to distribute the enrollment/disenrollment form through their member services departments within 3 workings days of receiving a telephone or written request for a form. Member Services representatives are to instruct Medi-Cal beneficiaries to submit the forms to the HCO enrollment contractor in the postage paid envelopes provided to the member.

The HCO enrollment contractor has access to the Medi-Cal Eligibility Data System (MEDS) to conduct on-line enrollment of eligibles. The MEDS is updated monthly. The effective date of plan enrollment will normally be fifteen (15) to forty-five (45) days after Medi-Cal eligibility determination and plan selection, depending on the day of the month and the "cut-off" date of the MEDS cycle. If the enrollment request is processed before the monthly update to the MEDS, enrollment shall be effective on the first day of the month following the month in which the request is processed. If the enrollment request is processed after the monthly update to the MEDS, enrollment shall be effective on the first day of the second month following the month in which the request is processed.

Contractor shall accept and forward to the HCO enrollment contractor, requests for enrollment and disenrollment as allowed by Title 22, CCR, Section 53889(h)(5). A request for disenrollment shall be made when a member meets any of the conditions stipulated in Title 22, CCR, Section 53891(a). Disenrollment requests meeting the criteria in Title 22, CCR, Section 53889(j) shall be processed as an expedited disenrollment. The effective date of disenrollment is the same as for an enrollment request stated above, except for expedited disenrollment requests. Expedited disenrollment requests shall be effective on the first day of the month in which the request is processed, whether submitted before or after the monthly update to the MEDS.

B. Time Schedule

Below is the tentative time schedule for this procurement:

Event	Date	Time (If applicable)
RFP Released	02/03/03	
Data Library Opens	02/03/03	

J. Qualification Requirements

Failure to meet the following requirements by the proposal submission deadline will be grounds for DHS to deem a Proposer nonresponsive. Evaluators may choose not to thoroughly review or score proposals that fail to meet these requirements. In submitting a proposal, each Proposer must certify and prove that it possesses the following qualification requirements.

1. Knox-Keene Licensure

Proposers shall have a current unrestricted Knox-Keene license showing authority to operate in the State.

2. Attestation

DHS may refuse to enter into a contract with a Proposer if any person who has an ownership or a controlling interest in the Proposer's firm or is an agent or managing employee of the Proposer, has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare. Proposer shall submit an Attestation to confirm that Proposer has no such relationships with such a person is required.

3. Contract Terms and Conditions Certification

Proposers must certify that they have read and are willing to comply with all proposed terms and conditions addressed in the RFP section entitled, "Contract Terms and Conditions," including the terms appearing in the referenced contract exhibits.

4. Disabled Veteran Business Enterprise (DVBE) Participation

Proposers must either achieve actual Disabled Veteran Business Enterprise (DVBE) participation **or** make an adequate Good Faith Effort (GFE) to meet the DVBE participation requirements. Detailed requirements are outlined in Attachment 8 (DVBE Instructions/Forms).

K. Proposal Format and Content Requirements

1. General instructions

a. Each firm or individual can submit only one (1) proposal per county. A Proposer may compete in more than one (1) county. The DHS will make a separate contract award to the most responsive and responsible firm or individual earning the highest score for each county included in the Central Valley RFP. Therefore, Proposers are submitting proposals with the understanding that in the event they submit proposals for multiple counties, but are awarded a contract for fewer counties than the number for which they have submitted proposals, they agree to contract with DHS for that smaller number of counties.

For the purposes of this paragraph, "firm" includes a parent corporation of a firm and any other subsidiary of that parent corporation. If a firm or individual submits more than one proposal per county, DHS will reject all proposals submitted by that firm or individual.

b. Develop proposal(s) by following all RFP instructions or clarifications issued by DHS in the form of question and answer notices, clarification notices, Administrative Bulletins or RFP addenda.

c. Before submitting your proposal(s), seek timely written clarification of any requirements or instructions that you believe to be vague, unclear or that you do not fully understand.

d. In preparing your proposal response, all narrative portions should be straightforward, detailed and precise. DHS will determine the responsiveness of a proposal by its quality, not its volume, packaging or colored displays.

e. Arrange for the timely delivery of your proposal package(s) to the address specified in this RFP. Do not wait until shortly before the deadline to submit your proposal(s).

2. Format requirements

a. Submit a separate proposal set of one (1) complete original proposal (Master) and three (3) complete copies of the proposal for each county for which you are submitting a proposal. Also, submit a copy of the Master on CD-R.

1) Write **"Master"** on the original proposal.

2) Indicate the corresponding county that the proposal is for on each proposal set on the Master and copies submitted.

3) Each proposal set must be complete with all required attachments and documentation.

b. If you are competing for more than one county, please submit one "Reference Set" that includes all of the Technical Proposal Requirement (TPR) categories submitted that contain identical responses for each county for which you are submitting a proposal i.e. If a Proposer submits a proposal for three (3) counties and the responses for TPR categories 1. Organization and Administration of Plan and 3. Management Information Systems are identical then these would be included in the Reference Set.

The purpose of the Reference Set is to identify those TPR categories of a Proposer's separate county proposals that are identical in response and require a single evaluation.

1) For Proposers submitting proposals for more than one county, write "Reference Set" on the reference set.

c. Format the narrative portions of the proposal as follows:

1) Use one-inch margins at the top, bottom, and both sides.

2) Use a font size of not less than 11 points.

3) Print pages single-sided on white bond paper.

4) Sequentially paginate the pages in each section. It is not necessary to paginate items in the Forms Section or Appendix Section.

d. Bind each proposal set in a way that enables easy page removal. Loose leaf or three-ring binders are acceptable.

those services. Also indicate all other assumptions made in preparing the projected cash flow statements in Item HH-2-c.

f) Exhibit HH-3-f: Description and Disclosure of Compliance with Tangible Net Equity Requirements:

i. Exhibit HH-3-f-i: A detailed description of any measures taken or proposed to be taken to maintain compliance with the tangible net equity requirement under Title 28, CCR, Section 1300.76 and the financial viability requirement under Title 28, CCR, Section 1300.76.1 in view of losses and expenditures prior to reaching a break-even point in operations. This information should include a schedule setting forth the amounts of any additional needed funding and the dates when such amounts will be infused into Proposer.

If such arrangements involve arrangements for additional capital, to subordinate or postpone the payment of accounts, notes or other obligations of the plan or other agreements, attach copies of such agreements or proposed agreements, identifying their applicable provisions, and identify the parties thereto and their relationship to the plan and its affiliates.

ii. Exhibit HH-3-f-ii: If any funding is to be obtained from an entity other than a national bank or a bank incorporated under the laws of this State, attach a copy of such entity's most recent annual audited and quarterly unaudited financial statements.

2) Exhibit HH-4 (Projected Reimbursements): Include the following information regarding projected reimbursements:

a) Monthly and quarterly projected reimbursements (cash basis). Refer to California Health & Safety Code, Section 1377(a) for items i. through iii. Include:

i. Payments to reimburse non-contracting providers for covered health care services furnished to Medi-Cal members.
ii. Payments to reimburse Medi-Cal members for covered health care services furnished by non-contracting providers.
iii. Total reimbursements for services by non-contracting providers (i.) plus (ii.).
iv. Fee-for-service payments to reimburse contracting providers for covered health care services.
v. Total reimbursements (iii.) plus (iv.).
vi. Total expenditures by Proposer for covered health care services.
vii. The ratio of total reimbursements to total health care expenditures (v.) divided by (vi.).
viii. The ratio of reimbursements for services by non-contracting providers to total expenditures (iii.) divided by (vi.).

b) Describe and substantiate the facts and assumptions upon which the projections are based, including those for fee-for-service payments to contracting providers and document the source and validity of such assumptions. (Actuarial studies or comparable information should be furnished in response to these items.).

c) In addition to Exhibit HH-4, part b., include a description of the Proposer's reimbursement arrangement with providers and all subcontractors, including any financial incentives. For providers who are to be paid per claim or per diem, include a description on how Proposer determines the provision for incurred, but not reported (IBNR) claims.

3. Management Information System

a. Proposer shall provide an organization chart of proposed or existing staffing for the MIS and Claims Department(s). Identify the position(s) and person(s) responsible for the MIS system reporting relationship between providers/sites and plan operations. Include the reporting relationship(s) of staff involved in the collection and processing of the data. Job descriptions should include reference to MIS functions and/or oversight activities as appropriate to either the MIS or Claims Processing Department.

b. Proposer shall provide an overview of the MIS including the hardware and software used and how each is related to other components of the system; i.e., service bureau, LAN system, mini-computer mainframe, etc.

c. Proposer shall provide a summary description of the proposed and/or existing MIS including a description of the components, related levels of automation or manual operation, and the linkages between subsystems (i.e., Financial; Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Assurance/ Utilization; and, Report Generation).

4. Quality Improvement System

a. Proposer shall submit an organization chart showing key staff and the committees and bodies responsible for Quality Improvement (QI) Activities including reporting relationships of the Quality Improvement System (QIS) committee(s) and staff within the Proposer's organization. Include qualifications for key positions.

b. Proposer shall provide an example of a recent quality of care issue involving a physician. Include how the issue was discovered, reported, and communicated through the QI committees to reach resolution.

c. Proposer shall describe its oversight and monitoring of QI activities that have been delegated to other entities, which have been undertaken over the past year. Provide specific examples of oversight and monitoring activities.

d. Proposer shall describe experience with Medi-Cal Health Plan Employer Data and Information Set (HEDIS). Describe internal chart retrieval process and provide Medi-Cal scores for the HEDIS data collected in the year 2000, for the following 7 measures;

1) Initiation of Prenatal care
2) Prenatal care in the first trimester
3) Check-ups after Delivery
4) Childhood Immunization Status Combination 2 - 4:3:1:2:3:1 series
5) Well Child Visits in the First 15 Months of Life (6 or more visits)
6) Well-Child Visits in the 3rd, 4th, 6th year of life
7) Adolescent Well-Care Visits

If Medi-Cal scores are not available, provide HEDIS scores for another product line. Identify the product line, service area and date of score.

e. Proposer shall describe how they integrate their consumer satisfaction survey findings into the QIS program. Provide examples of activities taken as a result of consumer satisfaction findings.

f. Proposer shall describe any innovative QI activities that demonstrate their commitment to exceeding the minimum requirements as set forth in the Contract.

5. Utilization Management

a. Proposer shall describe its Utilization Management (UM) system including organizational structure and placement in the organization. Proposer shall reference where this organizational component is presented in the organization chart required in technical proposal requirement 1.a.2)a). Narrative should include an explanation of the functions of the UM staff, and the relationship of UM to the other parts of the organization.

b. Proposer shall submit a UM log and reports reflecting prior authorizations for the most recently completed three month period that includes the following information:

1) Prior authorization requests submitted, approved, deferred, denied or modified.
2) Turnaround times for the adjudication of the pre-authorization requests mentioned above.
3) Denials that were appealed and overturned.

c. Proposer shall describe what UM activities are delegated to subcontractors. Describe how oversight, tracking, and monitoring of the delegated activities are conducted. Provide a sample report from a delegated entity that illustrates UM activity performance.

d. Proposer shall describe any innovative UM activities that demonstrate their commitment to exceeding the minimum requirements as set forth in Contract.

6. Provider Network

a. Proposer shall submit a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) used should be of convenient size and of the largest scale sufficient to include the entire proposed Service Area in which eligible Medi-Cal members live. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas and regions of the state, such as those commonly available from automobile associations or retail service stations, are preferred. The maps shall show:

1) Geographic detail, including highways and major streets.

2) Boundaries of proposed county.

3) Location of any contracting or plan-operated hospital and, if separate, each contracting or plan-operated emergency health care facility. Hospitals are to be designated by an "H" and emergency care facilities by an "E."

4) Location of Primary Care Providers, designated by a "P" (for providers who have signed subcontracts) or "PL" (for primary care providers who have submitted letters of intent). For convenience, the Primary Care Providers within any mile-square area may be considered as one location within that area.

5) Location of after-hours urgent care centers, designated by a "U."

6) Location of all other contracting or plan-operated health care providers including the following:

a) Pharmacy, designated by an "Rx."
b) Laboratory, designated by an "L."
c) Eye Care, designated by an "O."
d) Specialists and ancillary healthcare providers, designated by an "S."

Add an "L" for providers who have submitted a letter of intent; i.e., Pharmacy "RxL," Laboratory "LL," Eye Care "OL."

b. Proposer shall submit an index to the map(s) furnished in item a. above which shows, for each symbol placed on the map for a Primary Care Provider, specialist, ancillary provider, hospital, or emergency care facility, the following information:

1) For each symbol for Primary Care Providers, identify the type of Primary Care Provider (physician, family nurse practitioner, physician assistant), give the number of full-time equivalent Primary Care Physicians available to Medi-Cal members, and the aggregate number of Medi-Cal members those Primary Care Physicians will accept.

2) Identify all providers who are Traditional or Safety-Net Providers.

3) Identify the types of specialists (Cardiology, Endocrinology) and ancillary healthcare providers (physical therapy, durable medical equipment).

c. Proposer shall submit lists of Physicians who will provide covered physician services to Medi-Cal members. Lists must be arranged by Physician specialty and by zip code. Provide separate lists for Primary Care Physicians and specialists.

Proposers must submit provider information in hard copy and electronic media using the report form in Program Appendices, Appendix 12, Primary Care Physicians, and Appendix 13, Physicians - Specialists. All electronic media must be submitted on a 3.5 inch diskette or CD and in Microsoft Word Excel or Access formats (1997 or 2000 version) or in an ASCII text format. See Program Appendices, Appendix 14 for file layout. For each Physician, furnish the following information: (Use a separate row for each location at which a provider practices.)

1) Name. (Last, First)

2) Professional license number.

3) Medi-Cal identification number, if applicable.

MIS Overview (Technical Proposal Requirement 3.b)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
When evaluating this question, consider the following: Is the software/hardware design capable of performing all required and proposed MIS functions, at the standards and volumes to be reasonably expected for this contract?			

MIS/Subsystems System Description (Technical Proposal Requirement 3.c.)		Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
9.	To what extent does the Proposer provide a summary description of the MIS components (existing and/or proposed), related level(s) of automation or manual operation, and the linkages between the system components (i.e., Financial; Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Assurance/ Utilization; and, Report Generation)?		50	

When evaluating this question, consider the following:

A. The proposal includes comprehensive description and flowcharts of the overall MIS functions; description of each program's logic; and processing steps with decision tables and program logic flowcharts as appropriate.

B. Proposal includes flow charts for each sub-system showing input, output and linkages between system components and indicating which are manual operations vs. automated functions.

C. The proposal substantially describes the inputs, outputs, files and system processes demonstrating the system's capabilities and functions.

D. Information may be accessed through use of multiple fields?

E. The proposal identifies comprehensive edits of all significant data fields used to record information.

F. Conversion of data into computer media is controlled and verified for accuracy and completeness?

G. Controls described for read/write authorizations, data base access?

H. Proposal demonstrates all subsystems are linked to permit the interchange of critical information?

I. Are data linkages integrated and/or interfaced?

Integration: Systems are said to be integrated when a data dictionary is used to manage multiple files for two or more subsystems, thus giving the appearance of a

MIS/Subsystems System Description (Technical Proposal Requirement 3.c.)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
single data base to the end user. Interfacing: Systems are said to be interfaced when there are two or more subsystems with separate master files for each subsystem and information is passed between the subsystems using programs and sometimes special hardware to accomplish the exchange of information. If the linkages are achieved through the interfacing of foreign subsystems, is the transmission of data between processing subsystems controlled? J. Are the Member/provider statistics integrated or interfaced? K. Capability for on-line inquiry access for Member and provider eligibility information/verification within plan? external access? L. Appropriate history files for Member, provider, financial data are maintained? M. Proposal describes the establishment of provider, eligibility, procedures, diagnosis, and formulary files, including the creation of an enrollee file, based on Member information received from the Department, and a suspense file if necessary? N. Documentation describes the report generation process and capability to produce ad hoc reports and files on an as needed basis to support plan management functions?			

FINAL SCORE: Management Information Systems

Total Points Earned _____

4. QUALITY IMPROVEMENT SYSTEMS

Summary of Points	Maximum Score		Weight		Total Pts. Possible
Organizational Structure (Technical Proposal Requirement 4.a.)	3	X	10	=	30
Communication between Quality Improvement Committee and Governing Body (Technical Proposal Requirement 4.b.)	3	X	8	=	24
Oversight Activities (Technical Proposal Requirement 4.c.)	3	X	20	=	60
HEDIS Experience (Technical Proposal Requirement 4.d)	3	X	42	=	126

Consumer Satisfaction Surveys (Technical Proposal Requirement 4.e.)	3	X	10	=	30
Innovative Quality Improvement Activities (Technical Proposal Requirement 4.f.)	3	X	10	=	30
Total Possible Points	3	X	100	=	300

Evaluation Criteria

Organizational Structure (Technical Proposal Requirement 4.a)	**Points Awarded (0-3)**	**Multiplied by Weight**	**Equals Total Points Earned**
10. To what extent did Proposer submit an organization chart showing key staff, their qualifications, and the committees/bodies responsible for Quality Improvement (QI) activities?		10	

When evaluating this question, consider the following:

A. Did Proposer describe reporting relationships of QI staff to other areas within the organization?

1) Does Quality Improvement System organizational chart include a Physician who consults or provides oversight?

B. Does the Proposer's Quality Improvement Committee (QIC) include provider participation from provider network Physicians?

C. Are the qualifications for the key positions commensurate with the responsibilities?

Communication between QIC and Governing Body (Technical Proposal Requirement 4.b)	**Points Awarded (0-3)**	**Multiplied by Weight**	**Equals Total Points Earned**
11. To what extent did Proposer provide a comprehensive example of a recent quality of care issue involving a Physician that included the following?		8	

A. A system to identify, track and trend quality of care issues.

B. The quality of care issue was communicated from the QIC to the Governing Body.

C. Review by a peer review body with the ability to appeal the decision.

D. Review and discussion of the quality of care issue by the Governing Body.

Communication between QIC and Governing Body (Technical Proposal Requirement 4.b)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
E. Action by the Governing Body and follow-up to resolution F. Actions taken and results communicated to the appropriate people (health plan, provider, and member).			

Oversight Activities (Technical Proposal Requirement 4.c.)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
12. To what extent does Proposer's oversight and monitoring activities over the past year demonstrate a systematic approach that includes the following?		20	
A. Collection or onsite review of delegated entities QIC minutes. B. Collection and review of quarterly (or annual) QI activity reports. C. Incorporation of delegated entity's QI findings into Proposer's health plan QI process. D. Identification of specific problems for follow-up. E. Review of delegated entity's compliance to Proposer's QI standards (i.e. Access and Availability, Utilization Management, Credentialing etc.). F. Assessment of specific actions for follow-up.			

HEDIS Experience (Technical Proposal Requirement 4.d.)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
13. To what extent did Proposer describe experience with Medi-Cal Health Plan Employer Data and Information Set (HEDIS)?		(42 total, see below)	
When evaluating this question, consider the following: A. Rate the Proposer's HEDIS 2000 Medicaid scores (Medi-Cal for California) by comparing them to the following HEDIS Medi-Cal scores for 2000: If there is a "not report" in any of the seven performance measures, no points are to be allocated for that performance measure.			
1) Initiation of Prenatal Care <72.1% = 0 pts ≥72.1% = 3 pts		6	

2) Prenatal Care in the 1st Trimester <61.4% = 0 pts ≥61.4% = 3 pts		6	
3) Check-ups After Delivery <46.5% = 0 pts ≥46.5% = 3 pts		6	
4) Childhood Immunizations Status (combination 2) <44.3% = 0 pts ≥44.3% = 3 pts		6	
5) Well-Child Visits in the first 15 months of Life <32.9% = 0 pts ≥32.9% = 3 pts		6	
6) Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life <56.7% = 0 pts ≥56.7% = 3 pts		6	
7) Adolescent Well-Care Visits <29.9% = 0 pts ≥29.9% = 3 pts		6	

HEDIS Experience (Technical Proposal Requirement 4.d.)	**Points Awarded (0-3)**	**Multiplied by Weight**	**Equals Total Points Earned**
Proposer cannot score points for this Evaluation Criteria (EC), if they submitted Medi-Cal HEDIS scores and earned points for EC 13.A, (1 through 7). B. If Proposer does not report Medi-Cal HEDIS scores, did they report HEDIS scores for another product line, and include service areas and dates?		12	

Consumer Satisfaction Surveys (Technical Proposal Requirement 4.e.)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
14. To what extent does Proposer's description of how they integrate their consumer satisfaction survey findings into the QIS program and does it include the following?		10	
A. Consumer satisfaction survey findings are presented at QIC meetings and communicated to the Governing Body. B. Examples indicate quality initiatives derived from consumer concerns. C. Indication that actions taken based on consumer satisfaction survey findings resulted in improvement.			

Innovative Quality Improvement Activities (Technical Proposal Requirement 4.f.)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
15. Did Proposer describe Quality Improvement activities beyond Contract requirements that have the potential of improving access to care, quality of care and/or Member satisfaction?		10	
To what extent does the activities exceed minimum requirements?			

FINAL SCORE: Quality Improvement Systems

Total Points Earned _____

5. UTILIZATION MANAGEMENT

Summary of Points	Maximum Score		Weight		Total Pts. Possible
Utilization Management System (Technical Proposal Requirement 5.a)	3	X	15	=	45
Utilization Management Activities (Technical Proposal Requirement 5.b.1)	3	X	10	=	30
(Technical Proposal Requirement 5.b.2)	3	X	30	=	90
Delegated Utilization Management Activities (Technical Proposal Requirement 5.c)	3	X	35	=	105
Innovative Utilization Management Activities (Technical Proposal Requirement 5.d)	3	X	10	=	30
Total Possible Points	3	X	100	=	300

EVALUATION CRITERIA

Utilization Management System (Technical Proposal Requirement 5.a)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
16. To what extent did Proposer's organization chart include the following?		15	
A. Did the proposer demonstrate Utilization Management's (UM) structure and placement within the organization? B. Is there an explanation of the functions of UM staff and lines of reporting responsibilities? C. Is there a description of the UM's relationship to other parts of the organization?			

Utilization Management Activities (Technical Proposal Requirement 5.b.1)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
17. To what extent do the submitted log and reports adequately demonstrate the Proposer's ability to perform the pre-authorization activities?		10	
When evaluating this question, consider the following: Does the data indicate that the overturned denial rate is between 0-10%? *(Denial Rate ≤10% = 3 pts.; > 10% = 0 pts.)*			

Utilization Management Activities (Technical Proposal Requirement 5.b.2)	Points Awarded (0-3)	Multiplied by Weight	Equals Total Points Earned
18. To what extent do the log and reports submitted by the Proposer indicate the following?		30	
A. Provider was allowed 30 days to submit additional information on deferred prior authorization requests? B. A disproportionate approval rate of a specific service? C. Turnaround times for the following are contractually met: 1) Routine prior authorization requests completed within five (5) business days from receipt of information necessary to render a decision. 2) Concurrent review prior authorization requests within seventy-two (72) hours or consistent with urgency of members medical condition. 3) Appeals are resolved within 30 days.			

Required Attachment / Certification Checklist

Qualification Requirements. I certify that my firm meets the following requirements:		Confirmed by DHS
☐ Yes ☐ No	My firm has a current unrestricted Knox-Keene license with authority to operate in the State. Provide copy of license with service area(s) indicated.	☐ Yes ☐ No
☐ Yes ☐ No	**Attestation**: My firm has no relationship (any person who has an ownership or a controlling interest in the firm or is an agent or managing employee of the Proposer) with a person who has been convicted of a criminal offense related to that involvement in any program under Medicaid (Medi-Cal), or Medicare.	
☐ Yes ☐ N/A	My firm has read and is willing to comply with the terms, conditions and contract exhibits addressed in the RFP section entitled, "Contract Terms and Conditions".	☐ Yes ☐ No
☐ Yes ☐ N/A	**(Corporations)** My firm is in good standing and qualified to conduct business in California. **[Check "N/A" if not a Corporation.]**	☐ Yes ☐ No
☐ Yes ☐ N/A	**(Nonprofit Organizations)** My firm is qualified to claim nonprofit status. **[Check "N/A" if not a nonprofit organization.]**	☐ Yes ☐ No
☐ Yes ☐ N/A	My firm has a past record of sound business integrity and a history of being responsive to past contractual obligations. My firm authorizes the State to confirm this claim.	☐ Yes ☐ No
☐ Yes ☐ N/A	My firm has complied with the DVBE actual participation and/or good faith effort requirements as instructed in the DVBE Instructions / Forms (Attachment 8). **[Check N/A if your total bid is under $10,000.]**	☐ Yes ☐ No
Technical Proposal format and content.		**Confirmed by DHS**
☐ Yes ☐ N/A	My firm complied with the Technical Proposal format requirements and my firm submitted one original Technical Proposal and five (5) copies. My proposal is assembled in the following order:	☐ Yes ☐ No
☐ Yes ☐ N/A	Proposal Cover Page (Attachment 1)	☐ Yes ☐ No
☐ Yes ☐ N/A	Table of Contents	☐ Yes ☐ No
☐ Yes ☐ N/A	Executive Summary section (3 pages or less)	☐ Yes ☐ No
☐ Yes ☐ N/A	Technical Proposal Requirements response section.	☐ Yes ☐ No
☐ Yes ☐ N/A	Forms section.	☐ Yes ☐ No
Form section with the following attachments / forms:		**Confirmed by DHS**
☐ Yes ☐ N/A	Attachment 2, Required Attachment / Certification Checklist	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 3, Proposer Certification Sheet	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 4, Proposer References	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 5, RFP Clause Certification	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 6, CCC 103 – Certification	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 7, Payee Data Record. **[Check "N/A" if you have had a prior contract with DHS.]**	☐ Yes ☐ No

☐ Yes ☐ N/A	Actual DVBE Participation (Attachment 8a) and DVBE certifications for each subcontractor or supplier listed. Complete this form according to the instructions in Attachment 8 if you attained partial or a full 3% DVBE participation. **[Indicate "N/A" if you achieved zero participation and chose to complete the good faith effort form or indicate "N/A" if the proposed cost for the entire contract term is under $10,000.]**	☐ Yes ☐ No
☐ Yes ☐ N/A	Good Faith Effort (Attachment 8b) and applicable GFE documentation. Complete this form if you did not attain a full 3% DVBE participation. **[Check "N/A" if you achieved a full 3% DVBE participation and submitted Attachment 8a or check "N/A" if the proposed cost for the entire contract term is under $10,000.]**	☐ Yes ☐ No

Name of Firm:	
Printed Name/Title:	
Signature	Date:

IMPLEMENTATION PLAN AND DELIVERABLES

The Implementation Plan and Deliverables section describes DHS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning Operations.

Once the Contract is awarded, the Contractor has 15 days after they sign the contract to submit a Workplan for each county that describes in detail how and when the Contractor will submit and complete the deliverables to DHS in accordance with the Implementation Plan and Deliverables section. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plans in the event of implementation delays.

The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period (approximately 6 months after the effective date of the contract). The Operations Period is the period of time beginning with the effective date of the first month of operations and continues on through the last month of capitation and services to Members.

The Contractor's Workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. DHS will review and approve each of the Workplan(s). However, Contractor shall not delay the submission of deliverables required in the Workplan(s) while waiting for DHS approval of previously submitted deliverables required by the Workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved DHS Workplan(s). In the event the Contractor fails to submit all deliverables in accordance with the milestones and timeframes in the approved DHS Workplan(s), DHS may impose Liquidated Damages in accordance with Exhibit E - Additional Provisions, Attachment 2 - General Terms and Conditions, provision 17. Liquidated Damages Provisions.

In the event that this section omits a deliverable required by the Contract, the Contractor will still be responsible to assure that all contract requirements are met. Upon successful completion of the Implementation Plan and Deliverables section requirements, DHS will authorize, in writing, that the Contractor may begin the Operations Period.

Knox-Keene Licensure

If not currently licensed to operate in awarded service area, a complete material modification to operate in the service area must be submitted to the DMHC within 30 days of award of contract. Submit proof of the material modification submission to DHS concurrently. Operation shall not begin until the material modification is approved by DMHC.

1. Organization and Administration of Plan

a. Submit documentation of employees (current and former State employees) who may present a conflict of interest.

b. Submit a complete organizational chart.

c. If the Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.

d. Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.

e. Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's Public Policy Advisory Committee.

f. Submit the following Knox-Keene license exhibits and forms reflecting current operation status:

1) Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the health plan.

a) Corporation: Exhibits F-1-a-i through F-1-a-iii and Corporation Information Form, Form HP 1300.51-A. (See Appendix 8 of RFP)
b) Partnership: Exhibits F-1-b-i and F-1-b-ii and Partnership Information Form, Form HP 1300.51-B. (See Appendix 9 of RFP)
c) Sole Proprietorship: Exhibit F-1-c and Sole Proprietorship Information Form, Form HP 1300.51-C. (See Appendix 10 of RFP)
d) Other Organization: Exhibits F-1-d and F-1-d-ii, and Information Form for other than Corporations, Partnerships, and Sole Proprietorships, Form HP 1300.51-D.
e) Public Agency: Exhibits F-1-e-I through F-1-e-iii.

Title 28, CCR, Section 1300.51(d)(F)(1)(a) through (e)

2) Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above. (See Appendix 11 of RFP)
Title 28, CCR, Section 1300.51(d)(F)(1)(f)

3) Exhibits F-2-a and F-2-b: contracts with Affiliated person, Principal Creditors and Providers of Administrative Services.

4) Exhibit F-3 Other Controlling Persons.

Title 28, CCR, Section 1300.51(d)(F)

5) In addition to Exhibits F, Contractor shall demonstrate compliance with requirements of Title 22, CCR, Sections 53874 and 53600. Identify any individual named in this item b. that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.

g. Submit Exhibit M-2: Statements as to each person identified in Section L. Technical Proposal Requirements, provision 1. Organization and Administration, a. 2) (Exhibit L) and 3). (Exhibit M-1)

Title 28, CCR, Section 1300.51(d)(M)(2)

h. Submit Exhibits N-1 and N-2: Contracts for Administrative Services.

Title 28, CCR, Section 1300.51(d)(N)(2)

i. If, within the last five (5) years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor shall submit a summary of the circumstances surrounding the termination or non-renewal. Describe the parties involved, including address(es) and telephone number(s). Describe the Contractor's corrective actions to prevent future occurrences of any problems identified.

j. Contractor shall describe provisions and arrangements, existing, and proposed, for including Medi-Cal Members in their Public Policy Advisory Committee development process. Identify the composition and meeting frequency of any committee participating in establishing the Contractor's public policy. Describe the frequency of the committee's report submission to the Contractor's Governing Body, and the Governing body, and the Governing Body's process for handling reports and recommendations after receipt.

2. Financial Information

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Note: Where Knox-Keene license exhibits are requested, the descriptions of exhibit content may have been amended to address Medi-Cal program needs or industry terminology.

a. Submit most recent audited annual financial reports

b. Submit quarterly financial statements with the most recent quarter prior to execution of the Contract.

c. Submit the following Knox-Keene license exhibits reflecting projected financial viability:

1) Exhibit HH-1
2) Exhibit HH-2

(Title 28, CCR, Section 1300.76)

3) In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.

d. Submit Knox-Keene license Exhibit HH-6. Include the following:

1) Exhibit HH-6-a:
2) Exhibit HH-6-b:
3) Exhibit HH-6-c
4) Exhibit HH-6-d:
5) Exhibit HH-6-e:

Title 28, CCR, Section 1300.51(d)(HH)

e. Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with DHS. Also describe any reinsurance and risk-sharing arrangements with any subcontractors shown in this Proposal. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22, CCR, Sections 53863 and 53868.

f. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:

1) Exhibit II-1
2) Exhibit II-2
3) Exhibit II-3

Title 28, CCR, Section 1300.51(d)(II)

g. Describe systems for ensuring that subcontractors who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a subcontract, have the administrative and financial capacity to meet its contractual obligations. Title 28, CCR Section 1300.70(b)(2)(H)1. Title 22, CCR, Section 53250.

h. Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.

i. Describe it process to ensure timely filing of required financial reports. The description should include mechanisms for systems oversight for generating financial and operational information, including a tracking system with lead times and due dates for quarterly and annual reports. Describe how this process coincides with the organization's management information system. Additionally, Contractor shall describe how it will comply with the Administrative cost requirements in Title 22, CCR, Section 53864(b).

j. Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.

3. Management Information System

Note: Contractor's readiness for operation will be reviewed against the "Model MIS Guidelines" (Appendix 4 of RFP). See Appendix 6 of the RFP for additional information.

a. Submit a completed MCO Baseline Assessment Form (see Appendix 5 of RFP).

b. If procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:

1) Outline of the tasks required;
2) The major milestones;
3) The responsible party for all related tasks;

The implementation plan must also include:

1) A full description of the acquisition of software and hardware, including the schedule for implementation;
2) Full documentation of support for software and hardware by the manufacturer or other contracted party;
3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;
4) Documentation of system changes related to pending Health Insurance Portability and Accountability Act of 1996 requirements.

c. Submit a detailed description of how Proposer will monitor the flow of encounter data from provider level to the organization.

d. Submit Encounter data test tape produced from State supplied data.

e. Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.

f. Submit a work plan for compliance with the Health Insurance Portability and Accountability Act of 1996.

g. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.

h. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems;

1) Financial
2) Member/Eligibility
3) Provider
4) Encounter/Claims
5) Quality Management/Utilization

3. Management Information System

Note: Contractor's readiness for operation will be reviewed against the "Model MIS Guidelines" (Appendix 4 of RFP). See Appendix 6 of the RFP for additional information.

a. Submit a completed MCO Baseline Assessment Form (see Appendix 5 of RFP).

b. If procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:

1) Outline of the tasks required;
2) The major milestones;
3) The responsible party for all related tasks;

The implementation plan must also include:

1) A full description of the acquisition of software and hardware, including the schedule for implementation;
2) Full documentation of support for software and hardware by the manufacturer or other contracted party;
3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;
4) Documentation of system changes related to pending Health Insurance Portability and Accountability Act of 1996 requirements.

c. Submit a detailed description of how Proposer will monitor the flow of encounter data from provider level to the organization.

d. Submit Encounter data test tape produced from State supplied data.

e. Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.

f. Submit a work plan for compliance with the Health Insurance Portability and Accountability Act of 1996.

g. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.

h. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems;

1) Financial
2) Member/Eligibility
3) Provider
4) Encounter/Claims
5) Quality Management/Utilization

i. Submit a sample and description of the following reports generated by the MIS;

1) Member roster
2) Provider Listing
3) Capitation payments
4) Cost and Utilization
5) System edits/audits
6) Claims payment status/processing
7) Quality Assurance
8) Utilization
9) Monitoring of Complaints

4. Quality Improvement System

a. Submit a flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.

b. Submit policies that specify the responsibility of the Governing Body in the QIS.

c. Submit policies for the QI Committee including membership, activities, roles and responsibilities.

d. Submit procedures outlining how providers will be kept informed of the written QIS, its activities and outcomes.

e. Submit policies and procedures related to the delegation of the QIS activities.

f. Submit boilerplate subcontract language showing accountability of delegated QIS functions and responsibilities.

g. Submit a written description of the QIS.

h. Policies and procedures to address how the Contractor will meet the requirements of:

1) External Accountability Set (EAS) Performance Measures
2) Quality Improvement Projects
3) Consumer Satisfaction Survey

i. Submit policies and procedures for performance of Primary Care Provider site reviews.

j. Submit a list of sites to be reviewed prior to initiating plan operation

k. Submit the aggregate results of pre-operational site review to DHS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by DHS.

l. Submit policies and procedures for reporting any disease or condition to public health authorities.

m. Submit policies and procedures for credentialing and re-credentialing.

n. Submit policies and procedures for appropriate handling and maintenance of medical records regardless of form (electronic, paper, etc.).

5. Utilization Management

a. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services.

b. Submit policies and procedures for pre-authorization, concurrent review, and retrospective review.

c. Submit a list of services requiring prior authorization and the utilization review criteria.

d. Submit policies and procedures for the utilization review appeals process for providers and members.

e. Submit policies and procedures that specify timeframes for medical authorization.

f. Submit policies and procedures to detect both under- and over-utilization of health care services.

g. Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.

6. Provider Network

a. Submit complete provider network showing the ability to serve sixty percent (60%) of the Eligible Beneficiaries in the county pursuant to the Contract.

b. Submit policies and procedures describing how Contractor will monitor provider to patient ratios to ensure they are within specified standards.

c. Submit policies and procedures regarding physician supervision of non-physician medical practitioners.

d. Submit policies and procedures for providing emergency services

e. Submit a complete list of specialists by type within the Contractor's network.

f. Submit policies and procedures for how Contractor will meet Federal requirements for access and reimbursement for in-Plan and/or out-of-Plan FQHC services.

g. Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in the Contract.

h. Submit a policy regarding the availability of a health plan physician 24-hours a day, 7-days a week, and procedures for communicating with emergency room personnel.

i. Submit a report containing the names of all subcontracting provider groups (see Exhibit A, Attachment 6, provision 11).

j. Submit an analysis demonstrating the ability of the Contractor's provider network to meet the ethnic, cultural, and linguistic needs of the Contractor's Members.

k. Submit all boilerplate subcontracts.

l. Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.

m. Submit an attestation as to the percentage of Traditional and Safety-Net Providers in the Contractor's network and agreement to maintain that percentage.

7. Provider Relations

a. Submit policies and procedures for provider grievances.

b. Submit a written description of how Contractor will communicate the provider grievance process to subcontracting and non-contracting providers.

c. Submit protocols for payment and communication with non-contracting providers.

d. Submit copy of provider manual.

e. Submit a schedule of provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.

f. Submit protocols for communicating and interacting with all emergency departments in the Service Area.

8. Provider Compensation Arrangements

a. Submit policies and procedures regarding timing of capitation payments to primary care providers or clinics.

b. Submit description of any physician incentive plans.

c. Submit policies and procedures for processing and payment of claims.

d. Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract, to any Medi-Cal member.

e. Submit Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities subcontracts.

f. Submit policies and procedures for the reimbursement of Non-Contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).

g. Submit policies and procedures for the reimbursement to local health department and non-contracting family planning providers for the provision of family planning service, STD episode, and HIV testing and counseling.

h. Submit policies and procedures for the reimbursement of immunization services to local health department.

i. Submit policies and procedures regarding payment to non-contracting emergency services providers. Include schedule of per diem rates and/or Fee-for-service rates for each of the following provider types;

1) Primary Care Providers
2) Medical Groups and Independent Practice Associations
3) Specialists
4) Hospitals
5) Pharmacies

9. Access and Availability

a. Submit policies and procedures that include standards for:

1) Appointment scheduling
2) Routine specialty referral
3) First prenatal visit
4) Waiting times
5) Urgent care
6) After-hours calls
7) Unusual specialty services

b. Submit policies and procedures for the timely referral and coordination of Covered Service to which the Contractor or subcontractor has objections to perform or otherwise support.

c. Submit policies and procedures for standing referrals.

d. Submit policies and procedures regarding 24-hr./day access without prior authorization, follow-up and coordination of emergency care services.

e. Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.

f. Submit applicable section of Member Services Guide stating Member's right to access family planning services without prior authorization.

g. Submit policies and procedures for the provision of and access to:

1) Family planning services
2) Sexually transmitted disease treatment
3) HIV testing and counseling services
4) Pregnancy termination
5) Minor consent services
6) Immunizations

h. Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.

i. Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.

j. Submit a written description of the Cultural and Linguistic Services Program.

k. Submit a timeline and work plan for the development and performance of a Group Needs Assessment.

l. Submit policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors.

m. Submit policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.

n. Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

o. Submit policies and procedures describing the membership of the Community Advisory Committee (CAC) and how the Contractor will ensure the CAC will be involved in appropriate policy decisions.

10. Scope of Services

a. Submit policies and procedures for providing Initial Health Assessments (IHA) for adults and children. Include components (including Behavioral Health Assessment) of the IHA.

b. Submit policies and procedures, including standards, for the provision of the following services for Members under Twenty-One (21) years of age:

1) Children's preventive services
2) Immunizations

3) Blood Lead screens
4) Screening for Chlamydia
5) EPSDT supplemental services

c. Submit policies and procedures for the provision of adult preventive services, including immunization.

d. Submit policies and procedures for the provision of services to pregnant women, including:

1) Prenatal care
2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines
3) Comprehensive risk assessment tool for all pregnant women
4) Referral to specialists

e. Submit a list of appropriate hospitals available within the provider network that provide necessary high-risk pregnancy services.

f. Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration and oversight.

g. Provide a list and schedule of all health education classes and/or programs.

h. Submit policies and procedures for the provision of:

1) Hospice care
2) Vision care – Lenses
3) Mental health services
4) Tuberculosis services

i. Submit standards and guidelines for the provision of Pharmaceutical services and prescribed Drugs.

j. Submit a complete drug formulary.

k. Submit a process for review of drug formulary.

l. Submit policies and procedures for conducting drug utilization reviews.

11. Case Management and Coordination of Care

a. Submit procedures for monitoring the coordination of care provided to Members.

b. Submit policies and procedures for coordinating care of Members who are receiving services from a targeted case management provider.

c. Submit policies and procedures for the referral of Members under the age of 21 years that require case management services.

d. Submit policies and procedures for a disease management program. Include policies and procedures for identification and referral of Members eligible to participate in the disease management program.

e. Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the local Medi-Cal mental health plan or other community resources.

f. Submit policies and procedures for resolving disputes between Contractor and the local mental health plan.

g. Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance abuse treatment services from both within and, if necessary, outside the Contractor's Service Area.

h. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).

i. Submit policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program.

j. Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver program.

k. Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start program.

l. Submit policies and procedures for case management coordination of care of LEA services, including primary care physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.

m. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.

n. Submit a description of the cooperative arrangement Contractor has with the local school districts, including the subcontracts or written protocols/guidelines, if applicable.

o. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.

p. Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.

q. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.

r. Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.

s. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

t. Procedures to identify and refer eligible Members for WIC services.

u. Submit policies and procedures for the assessment and subsequent disenrollment of Members eligible for the following services:

1) Long-term care
2) Major organ transplants
3) Waiver programs

12. Local Health Department Coordination

a. Submit executed subcontracts or documentation substantiating Contractor's efforts to enter into subcontracts with the LHD for the following public health services:

1) Family planning services
2) STD services
3) HIV testing and counseling
4) Immunizations

b. Submit executed subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:

1) California Children Services (CCS)
2) Maternal and Child Health
3) Child Health and Disability Prevention Program (CHDP)
4) Tuberculosis Direct Observed Therapy
5) Women, Infants, and Children Supplemental Nutrition Program (WIC)
6) Regional centers for services for persons with developmental disabilities.

c. Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the local mental health plan.

13. Member Services

a. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.

b. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.

c. Submit policies and procedures for addressing advance directives.

d. Submit policies and procedures for the training of Member Services staff.

e. Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.

f. Submit final draft of Member Identification Card and Member Services Guide.

g. Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.

h. Submit policies and procedures for Member selection of a primary care physician or non-physician medical practitioner.

i. Submit policies and procedures for Member assignment to a primary care physician.

j. Submit policies and procedures for notifying primary care provider that a member has selected or been assigned to the provider within 7-days.

k. Submit policies and procedures demonstrating how, upon entry into the Contractor's network, the relationship between traditional and safety-net providers and their patients is not disrupted, to the maximum extent possible.

l. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.

14. Member Grievance System

a. Submit policies and procedures relating to Contractor's Member Grievance System.

b. Submit policies and procedures for Contractor's oversight of the Member Grievance System for the receipts, processing and distribution including the expedited review of grievances. Please include a flow chart to demonstrate the process.

c. Submit format for Quarterly Grievance Report.

15. Marketing

a. Submit policies and procedures for training and certification of marketing representatives.

b. Submit a description of training program, including the marketing representative's training/certification manual.

c. Submit Contractor's marketing plan.

d. Submit copy of boilerplate request form used to obtain DHS approval of participation in a marketing event.

16. Enrollments and Disenrollments

a. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting providers.

b. Submit policies and procedures for how Contractor will access and utilize enrollment data from DHS.

c. Submit policies and procedures relating to Member disenrollment, including, Contractor-initiated disenrollment.